		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025098

Facility Name: FREEBURG CARE CENTER

Address: 746 URBANA DRIVE (Number) FREEBURG (City) 62243 (Zip Code)

County: ST. CLAIR

Telephone Number: (618)539-5856 **Fax #** (618)539-3412

IDPA ID Number: 371062186001

Date of Initial License for Current Owners: 03/14/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Roger Bagley **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,688	10,936	687	13,311	8
9	SNF/PED					9
10	ICF	22,940	5,433		28,373	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,628	16,369	687	41,684	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.52%

D. How many bed-hold days during this year were paid by Public Aid?
337 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/16/79

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/16/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 687

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	164,578	9,785	7,400	181,763		181,763		181,763			1
2	Food Purchase		111,652		111,652	6,436	118,088	(749)	117,339			2
3	Housekeeping	85,804	11,231		97,035		97,035		97,035			3
4	Laundry	55,769	6,454		62,223		62,223		62,223			4
5	Heat and Other Utilities			78,904	78,904		78,904		78,904			5
6	Maintenance	27,069	15,153	24,297	66,519		66,519		66,519			6
7	Other (specify):*											7
8	**TOTAL General Services**	333,220	154,275	110,601	598,096	6,436	604,532	(749)	603,783			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,301,636	40,986	222,719	1,565,341	(6,857)	1,558,484		1,558,484			10
10a	Therapy	26,646		6,320	32,966		32,966		32,966			10a
11	Activities	37,949	665	2,160	40,774		40,774		40,774			11
12	Social Services	35,372		2,160	37,532		37,532		37,532			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,401,603	41,651	236,359	1,679,613	(6,857)	1,672,756		1,672,756			16
	C. General Administration											
17	Administrative	60,140		7,200	67,340		67,340		67,340			17
18	Directors Fees			3,600	3,600		3,600		3,600			18
19	Professional Services			158,575	158,575		158,575		158,575			19
20	Dues, Fees, Subscriptions & Promotions			13,610	13,610		13,610	(2,154)	11,456			20
21	Clerical & General Office Expenses	44,465	11,165	17,064	72,694		72,694	(8,499)	64,195			21
22	Employee Benefits & Payroll Taxes			249,917	249,917	421	250,338		250,338			22
23	Inservice Training & Education			711	711		711		711			23
24	Travel and Seminar			3,097	3,097		3,097		3,097			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			12,338	12,338		12,338		12,338			26
27	Other (specify):*											27
28	**TOTAL General Administration**	104,605	11,165	466,112	581,882	421	582,303	(10,653)	571,650			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,839,428	207,091	813,072	2,859,591		2,859,591	(11,402)	2,848,189			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FREEBURG CARE CENTER #0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,821	34,821		34,821	50,937	85,758			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,475	22,475		22,475	76,740	99,215			32
33	Real Estate Taxes			40,284	40,284		40,284		40,284			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			457,580	457,580		457,580	(232,323)	225,257			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,267	44,192	70,459		70,459		70,459			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		26,267	108,974	135,241		135,241		135,241			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,839,428	233,358	1,379,626	3,452,412		3,452,412	(243,725)	3,208,687			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,334	30		9
10	Interest and Other Investment Income	(9,039)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(749)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,583)	21		18
19	Entertainment				19
20	Contributions	(25)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(891)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,788)	20		28
29	Other-Attach Schedule	(366)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,107)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(231,618)	SCHVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (231,618)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,725)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LINE 29	$		1
2	1 YEAR OF IDPH LICENSE PD IN 1999	200	20	2
3	IHCA PAC DUES	(566)	20	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(366)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(749)	0	0	0	0	0	0	0	0	0	0	(749)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(749)	0	0	0	0	0	0	0	0	0	0	(749)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,154)	0	0	0	0	0	0	0	0	0	0	(2,154)	20
21	Clerical & General Office Expenses	(8,499)	0	0	0	0	0	0	0	0	0	0	(8,499)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,653)	0	0	0	0	0	0	0	0	0	0	(10,653)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,402)	0	0	0	0	0	0	0	0	0	0	(11,402)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,334	42,603	0	0	0	0	0	0	0	0	0	50,937	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,039)	85,779	0	0	0	0	0	0	0	0	0	76,740	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(360,000)	0	0	0	0	0	0	0	0	0	(360,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(705)	(231,618)	0	0	0	0	0	0	0	0	0	(232,323)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,107)	(231,618)	0	0	0	0	0	0	0	0	0	(243,725)	45

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
				LAND TRUST		RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 360,000	ST. CLAIR ESTATES	100.00%	$	$ (360,000)	1
2	V	32	INTEREST EXPENSE		ST. CLAIR ESTATES	100.00%	86,318	86,318	2
3	V	30	DEPRECIATION		ST. CLAIR ESTATES	100.00%	42,603	42,603	3
4	V	32	INTEREST INCOME		ST. CLAIR ESTATES	100.00%	(539)	(539)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 360,000			$ 128,382	$ * (231,618)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FRANK HEILIGENSTEIN	CONSULTANT	ADM. CONSULTA	3.44		2	5.00	ADM CONS.	$ 3,400	17/3	1
2	LARRY RHUTASEL	CONSULTANT	ADM. CONSULTA	6.90		2	5.00	ADM CONS.	3,800	17/3	2
3	FRANK HEILIGENSTEIN	DIRECTOR	BOARDMEMBER	3.44		N/A	N/A	DIRECTOR FEE	800	18/3	3
4	LARRY RHUTASEL	DIRECTOR	BOARDMEMBER	6.90		N/A	N/A	DIRECTOR FEE	800	18/3	4
5	JOHN SCHAUFLER	DIRECTOR	BOARDMEMBER	20.70		N/A	N/A	DIRECTOR FEE	700	18/3	5
6	HERSCHEL PARRISH SR.	DIRECTOR	BOARDMEMBER	13.78		N/A	N/A	DIRECTOR FEE	600	18/3	6
7	DALE TOWERS	DIRECTOR	BOARDMEMBER	6.90		N/A	N/A	DIRECTOR FEE	700	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	UNION PLANTERS BANK		X	REAL ESTATE MORTGAGE	$10,151.00	8-28-97	$ 1,050,307	$ 916,918	08/28/05	0.0850	$ 86,318	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,151.00		$ 1,050,307	$ 916,918			$ 86,318	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,050,307	$ 916,918			$ 86,318	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FREEBURG CARE CENTER **#** 0025098 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	38,126	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	40,284	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,158	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	38,126	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	40,284	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	28,653	8
	1996	32,654	9
	1997	36,225	10
	1998	38,126	11
	1999	40,284	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,405 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	150,000	1979	$ 22,480	1
2					2
3	TOTALS	150,000		$ 22,480	3

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1979	1979	$ 1,174,206	$	30	$ 39,140	$ 39,140	$ 852,926	4
5	10		1985	1985	227,899		30	7,597	7,597	117,753	5
6			1985	1986	3,116		30	104	104	1,508	6
7			1989	1989	2,110		27	78	78	936	7
8	10		1998	1997	411,348		39.5	10,415	10,415	36,401	8
	Improvement Type**										
9	PARKING LOT/ TITLE INSURANCE			1981	7,109		30	237	237	4,720	9
10	SIDEWALK			1983	908		20	45	45	788	10
11	LAUNDRY RENOVATIONS			1983	3,303		25	132	132	2,310	11
12	STORAGE BUILDING			1983	6,690		20	335	335	5,862	12
13	WINDOW REPLACEMENT			1983	967		30	32	32	560	13
14	KITCHEN RENOVATIONS			1983	734		25	29	29	508	14
15	VENTILATION SYSTEM/ INSULATION			1984	1,132		10			1,132	15
16	CONCRETE PAVING			1985	4,124		20	206	206	3,193	16
17	PARKING LOT			1986	2,518		10			2,518	17
18	STORAGE SHED			1987	10,213	681	15	681		9,193	18
19	DRIVEWAY			1988	3,990	266	15	266		3,325	19
20	DRIVEWAY			1989	1,465	98	15	98		1,127	20
21	ENTRY SIGN			1990	2,890	193	15	193		2,026	21
22	PARKING LOT			1990	11,951	797	20	598	(199)	6,279	22
23	SEWER			1990	17,548	1,170	25	702	(468)	7,371	23
24	LIGHTS			1990	1,140	76	10	57	(19)	1,140	24
25	HEAT PUMPS/COMPRESSOR			1990	2,527	168	8		(168)	2,527	25
26	SEWER REPAIRS/DRIVEWAY REPAIRS/PLUMBING			1991	4,471	298	15	298		2,832	26
27	ROOFTOP AIR CONDITIONER			1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING/DRIVEWAY REPAIRS			1992	10,838	723	15	723		6,146	28
29	CARPET			1992	14,036		5			14,036	29
30	PARKING LOT & DRIVEWAY			1993	14,900	993	15	993		7,448	30
31	FENCE/ PARKING LOT & DRIVEWAY			1994	6,672	445	15	445		2,893	31
32	CEILING TILE			1994	1,310		5			1,310	32
33	LANDSCAPING			1996	1,499	150	10	150		675	33
34	WATER HEATER			1996	3,426	228	15	228		1,026	34
35	5 TON CONDENSING UNIT			1996	1,195	120	10	120		540	35
36	TOTAL (lines 4 thru 35)				$ 1,960,835	$ 6,406		$ 63,902	$ 57,496	$ 1,105,609	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER LINE & GAS LINE FOR ADDITION			1997	633	63	10	63		221	9
10	AIR COMPRESSOR FOR FIRE SYSTEM			1997	1,244	83	10	124	41	434	10
11	CERAMIC TILE & LABOR FOR SHOWERS			1997	5,795	386	15	386		1,351	11
12	ROCK AND ROAD GRADING			1997	502	100	5	100		350	12
13	REMOVE DRIVEWAY & RECONCRETE			1997	4,274	285	15	285		997	13
14	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM			1997	503	50	10	50		175	14
15	TELEPHONE SYSTEM			1997	4,640	580	10	464	(116)	1,624	15
16	8 GE HEAT/COOL WALL UNITS			1997	7,624	952	10	762	(190)	2,667	16
17	cabinets,countertops,&labor for new nurses station & gutting of old			1998	6,073	405	15	405		1,012	17
18	expanded care plan office adding countertop & windows			1998	6,952	463	15	463		1,158	18
19	FIRE ALARM			1998	4,431	295	15	295		738	19
20	5 TON HEATING/A/C UNIT ROOF TOP			1998	2,918	195	15	195		487	20
21	PHONE JACKS INSTALLED			1998	777	52	15	52		130	21
22	4 GE HEAT/COOL UNITS			1998	3,884		10	388	388	970	22
23	replaced ceiling tile & contructed new storage cabinets in activity room			1999	4,951	495	10	495		743	23
24	ROOF TOP FAN			1999	866	58	15	58		87	24
25	WORK ON ROOFTOP A/C UNIT			1999	3,170	226	14	226		339	25
26	NEW ROOF ON WINGS A,B,&C			1999	16,397		10	1,640	1,640	2,460	26
27	WALLPAPER IN DINING ROOM			2000	1,255	126	5	126		126	27
28	gutted bathroom installed windows & worktop to convert to DON office			2000	2,374	119	10	119		119	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 79,263	$ 4,933		$ 6,696	$ 1,763	$ 16,188	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 150,467	$ 4,322	$ 13,839	$ 9,517	VAR	$ 90,160	37
38	Current Year Purchases	19,160	19,160	1,321	(17,839)	VAR	1,321	38
39	Fully Depreciated Assets	276,502				VAR	276,502	39
40								40
41	TOTALS	$ 446,129	$ 23,482	$ 15,160	$ (8,322)		$ 367,983	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,508,707	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 34,821	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 85,758	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 50,937	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,489,780	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.
   WE ONLY HIRE TRAINED AIDS

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3	hrs	$	260	$ 14,874	$	260	$ 14,874	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		104	7,192		104	7,192	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3,39/2	hrs		322	19,188	159	322	19,347	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				13,546		13,546	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen, tubefeeding, medical supplies Other (specify): lab, xray	39/2 39/3				2,938	12,562		15,500	13
14	TOTAL			$	686	$ 44,192	$ 26,267	686	$ 70,459	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FREEBURG CARE CENTER **#** 0025098 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,671	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	530,455		3
4	Supply Inventory (priced at COST)	3,055		4
5	Short-Term Investments	56,908		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 670,419	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	159,458		15
16	Equipment, at Historical Cost	278,463		16
17	Accumulated Depreciation (book methods)	(351,569)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 86,352	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 756,771	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 72,520	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	290,000		29
30	Accrued Salaries Payable	63,815		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,220		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,126		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SALES TAX ACCRUED	188		36
37	401K LIABILITY	2,055		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 491,924	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 491,924	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 264,847	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 756,771	$	48

***(See instructions.)**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 221,124	1
2	Restatements (describe):		2
3	RESTATE 1999 DISTRIBUTION TO LOAN FROM		3
4	STOCKHOLDERS	50,750	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 271,874	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	195,973	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(203,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (7,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 264,847	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,522,754	1
2	Discounts and Allowances for all Levels	41,152	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,563,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,295	6
7	Oxygen	10,145	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 75,440	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,039	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,039	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,648,385	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	598,096	31
32	Health Care	1,679,613	32
33	General Administration	581,882	33
	B. Capital Expense		
34	Ownership	457,580	34
	C. Ancillary Expense		
35	Special Cost Centers	70,459	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,452,412	40
41	**Income before Income Taxes (line 30 minus line 40)****	195,973	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 195,973	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **IL REPLACEMENT T ON FEDERAL TAX R**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,080	$ 45,905	$ 22.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,510	5,811	97,626	16.80	3
4	Licensed Practical Nurses	25,659	27,886	388,660	13.94	4
5	Nurse Aides & Orderlies	69,190	74,803	750,859	10.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,963	2,154	26,646	12.37	8
9	Activity Director	3,990	4,326	37,949	8.77	9
10	Activity Assistants					10
11	Social Service Workers	3,077	3,446	35,372	10.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,882	2,098	26,345	12.56	14
15	Cook Helpers/Assistants	16,321	17,922	138,233	7.71	15
16	Dishwashers					16
17	Maintenance Workers	2,044	2,268	27,069	11.94	17
18	Housekeepers	10,367	11,124	85,804	7.71	18
19	Laundry	5,777	6,385	55,769	8.73	19
20	Administrator	2,088	2,450	60,140	24.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,577	4,025	44,465	11.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) WARD CLERK	1,641	1,985	18,586	9.36	33
34	TOTAL (lines 1 - 33)	154,958	168,763	$ 1,839,428 *	$ 10.90	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 7,400	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant		480	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	900	10/3	39
40	Physical Therapy Consultant	112	6,126	10A/3	40
41	Occupational Therapy Consultant	3	194	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify) ADMINISTRATIVE		7,200	17/3	46
47	UTILIZATIONS REVIEW		1,200	10/3	47
48	PURCH (1366) BILLING(5658)		7,024	19/3	48
49	TOTAL (lines 35 - 48)	400	$ 37,844		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	41	$ 1,146	10/3	50
51	Licensed Practical Nurses	3,630	93,573	10/3	51
52	Nurse Aides	7,411	125,420	10/3	52
53	TOTAL (lines 50 - 52)	11,082	$ 220,139		53

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DARLENE GENTEMAN	ADMINISTRATOR	0	$ 49,678
KELLY MARTIN	ADMINISTRATOR	0	10,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,140

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANTS	$ 7,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 7,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MANAGEMENT	MANAGEMENT	$ 127,952
ADP	PAYROLL SERVICE	840
RICHARD BRESLIN	TAX RETURN PREP	500
M.E.S.	PURCHASING CONSULTANT	1,366
MIKRON	COMPUTER PROGRAMMIN(	173
KOHN, SHANDS, ELBERT, ETC.	LEGAL FEES	22,086
NCS HEALTHCARE	BILLING SERVICE	5,658
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 158,575

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,722
Unemployment Compensation Insurance	14,647
FICA Taxes	140,716
Employee Health Insurance	12,288
Employee Meals	421
Illinois Municipal Retirement Fund (IMRF)*	
HEP B & FLU VACCINES	1,379
EMPLOYEE PARTIES, AWARDS, GIFTS, ETC.	7,267
401 K CONTRIBUTIONS	898
TOTAL (agree to Schedule V, line 22, col.8)	$ 250,338

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,738
Health Care Worker Background Check	333
(Indicate # of checks performed 28)	
public relations & directory advertising(elim)	1,788
don dues(30) nagna(1887) subscriptions(269)	2,186
IHCA(4659)IHCA-PAC(566)(ELIM)	5,225
SAM'S DUES(55)business license(10)	65
INHAA DUES(75)annual corp filing fee(50)	125
CLIA LAB	150
Less: Public Relations Expense	(566)
Non-allowable advertising	(1,788)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,456

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,610
Seminar Expense	1,487
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,097

**See instructions.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1994	$ 1,220	3	$ 203	$	$	$	$	$	$	$	$
2	PAINTING	1996	2,756	3	919	919	459						
3													
4													
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16													
17													
18													
19													
20	TOTALS		$ 3,976		$ 1,122	$ 919	$ 459	$	$	$	$	$	$

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES RN'S&LPN'S

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA $4659.00

(3) Did the nursing home make political contributions or payments to a political action organization? YES IHCA-PAC If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7.9 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ N/A Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 64,782
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 421 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

FREEBURG CARE CENTER
SCHEDULE OF RECLASSIFICATIONS PGS 3&4 COLUMN 5
12/31/2000
ID#0025098

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	6857	
10	NURSING & MEDICAL RECORDS		6857
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	421	
2	FOOD PURCHASES		421
	RECL EMPLOYEE MEALS		